rism. Thus one of the four cases seemed to derive benefit; of another (Mr. Smith's) there was no evidence as to benefit or otherwise; whilst in the other two the disease had advanced so far, and the aneurism had such a very false sac, that scarcely any operation could be expected to produce any great good. These cases alone could not justify surgeons in discarding Fergusson's operation. But if had recourse to, it should be done early. For if these cases do not yield to ordinary treatment they generally become rapidly fatal, and the only chance of recovery then is to tie the artery as near to the external orifice of the sac as possible. As to introduction of foreign bodies into the sac to promote coagulation, he was of opinion that needles, which could be removed, were preferable to wire or horsehair. For in the latter cases—supposing recovery to take place—what would become of the foreign body?

Dr. ANDREW asked whether distal ligature might not in itself lead to harm. Cases occurred especially of cerebral embolism in young people, where the obstruction of an artery is followed by the formation of an aneurism on the cardiac side of the obstruction.

Mr. HEATH was glad to hear the consensus of opinion as to the propriety of the operation, which, however, he did not think did any good in his case. Careful perusal of Mr. Spence's case showed that it had but little effect on the sac itself. In Mr. Holden's case the patient was *in extremis*, but the sac gave way; and so in Mr. H. Smith's case, where an intrathoracic portion of the aneurism ruptured. Mr. Baker had referred to a case under Mr. Hulke's care. That patient had been previously seen by Mr. H. Smith, who proposed amputation. He then came under Mr. Hulke's care at the Middlesex Hospital, where an apparent cure was effected under diet, etc. He had looked up the authorities on the subject before coming to a conclusion. He was not aware of any case where the carotid had been ligatured, except one recorded by Butcher in his "Operative Surgery," where that vessel was secured by mistake. He was glad to hear that Mr. Holmes had not found any good effect from ergotin. The effect of the needles in his case was good, and had he known that the aneurism was so sacculated, he should have inserted more than he did, for he thought this a procedure which might be more widely pursued. The risk of hemorrhage from the insertion of fine needles was very slight; and the risk of the carrying any of the clot into the general circulation was no more than occurs under any form of treatment. Attempts to produce coagulation by the injection of fluids into the sac had been proved to be disastrous.—*Lancet*, Jan. 31, 1880.

Aneurism of the Left Hypogastric Artery.

Crisp has collected 105 and Lebert 103 cases of aneurism of the abdominal aorta and its branches, but among them is not a single one of aneurism of the hypogastric artery. This appears then to be so great a rarity that we copy from the *Bresl. Artzl. Zeitschrift* and *St. Petersburger Med. Wochenschrift*, No. 51, 1879, the report of such a case by Dr. BINSWANGER. The case occurred in an old woman of sixty-five, who died after two days' residence in the hospital. She presented œdema of both labia and lower extremities; complained of severe abdominal pain, and died after lying there two days in a semi-conscious condition.

On post-mortem examination an extensive endarteritis deformans was found in the abdominal portion of the aorta, the pelvic arteries, and the arteries of the lower extremities, while the vessels of the upper half of the body appeared healthy. This endarteritis had led to numerous cylindrical and sac-like dilatations of the terminal branches of the abdominal aorta, especially the common iliac and the right iliac. Besides these, a large aneurism, the size of the fist, had formed at the point of emergence of the gluteal and ischiatic arteries (anterior and posterior divisions?) from the left hypogastric. The entire wall of this latter vessel was involved. It lay deep in the iliac fossa, and had become firmly attached to the left ureter, the intestine, and the hypogastric vein. It was covered with peritoneum, and presented a rent on its anterior surface, hemorrhage from which was the cause of death. The entire sac was filled with old colourless blood clots. The aneurismal attachment to the left ureter and the compression of the latter had led to a consecutive hydronephrotic dilatation of the renal pelvis, a collection of concretions there, and multiple abscesses of the kidney tissue.

In reporting this case in the *Cincinnati Lancet and Clinic* (Feb. 21, 1880), Dr. P. S. C[onnêr] states that, so far as he has been able to learn, but one case of aneurism of the internal iliac has heretofore been reported (Sandifort, *Tabulæ Anatomicæ*, etc., Leyden, 1801). Broca (*Aneurysmes*, Paris, 1856) says: "If we should meet with an aneurism of the internal iliac, and if it should be diagnosticated, the primitive iliac artery ought to be tied. But the case has not yet presented itself. I do not know of a single example of aneurism developed *in the pelvis* upon the branches of this artery." In the museum of the Royal College of Surgeons, London, there is a specimen of aneurism of the pudic artery.

Treatment of Popliteal Aneurism by Esmarch's Bandage.

At a recent meeting of the Clinical Society of London (*Lancet*, Feb. 21, 1880) Mr. CHRISTOPHER HEATH read a paper on two cases of popliteal aneurism cured by the application of Esmarch's bandage. Case 1. A coal miner, aged thirty-two, admitted into University College Hospital on October 22, 1879, with a right popliteal aneurism, attributed to his working in a cramped position. No history of injury, sudden strain, or syphilis. He had had pain in the ham ten weeks before admission, and soon after the swelling appeared, which gradually enlarged to the size of a hen's egg. The right posterior tibial pulse was not perceptible. On Oct. 25th, at 3 P. M., half a grain of morphia was injected subcutaneously, and Esmarch's bandage applied to the leg as far as the lower border of the sac. A piece of Martin's bandage was then applied to the thigh from above down, and over it the elastic cord of Esmarch was fixed. The aneurismal sac was thus rendered tense and full of blood. At 4 P. M. bichloride of ethylene was administered and kept up till 6 P. M., when the tourniquet and bandages were removed, the former first. There was no pulsation, but an hour afterwards slight impulse could be felt. A Carte's compressor was then kept on the femoral till 9 A. M. next day. There was no recurrence of pulsation, and on Nov. 14th the case was shown to the Society. He then presented a hard, ovoid, non-pulsating swelling in the ham; and an enlarged artery could be traced on the inner side of the thigh and ham; the posterior tibial pulse could not be felt.

Case 2. A potman, aged thirty-seven, muscular and healthy, without signs of general vascular degeneration. His aneurism was longer and narrower than the other, and, there being no bruit, it was thought to be fusiform. Pain in the popliteal space had existed for six weeks. There was no history of syphilis, but he had rheumatic fever in 1874. On Dec. 3, 1879, Esmarch's bandage and tourniquet were applied for three and a half hours, the patient being under the influence of bichloride of ethylene. Pulsation immediately returned on removal of the bandage. An attempt to compress the artery by Carte's tourniquet failed from the pain caused by it. On Dec. 4th digital compression was tried from